**Frequently Asked Coding Questions (FAQ)**

**Question:**  Can a Congenital Echo code be reported if the patient has a history of a congenital defect that was surgically corrected?

According to the AMA CPT Assistant and AMA CPT Knowledge Base, congenital codes are used to report echocardiographic examinations for suspected complex congenital heart disease, or in the case of follow-up or limited examinations, are used to report a repeat echocardiographic study during or following a surgical or interventional repair procedure.

**Question: Is there reimbursement for 3D?**

Physician: 3D codes 76376 and 76377 are payable codes under the Medicare Part B Physician fee schedule; however, coverage of these services in conjunction with echocardiography procedures depends on local coverage determinations. Some other payers may reimburse separately.

Hospital Outpatient: Medicare does not separately reimburse for 3D for hospital outpatients. Rather, the payment is bundled into the base procedure. However, it is important that hospitals continue to establish charges and report these procedures to maintain accurate future rate-setting by Medicare. In addition, the reporting of these services is necessary for maintaining reimbursement with private payers (who may separately reimburse).

Note about medical necessity: Few payers have policies that specifically list the clinical indications for 3D echo. Generally, follow 3D clinical guidelines or 3D published literature that supports medical necessity (e.g., valvular disease, surgical planning). The medical record must reflect the clinical circumstance that warrants the addition of the 3D procedure. Report the applicable ICD-9 diagnosis code that supports the circumstance.

**Question**: Is TEE included in the CPT code for TAVR (33361)?

No. TEE may be reported separately from the TAVR procedure during the intraoperative session. This assumes a separate physician is providing the TEE service from the physician implanting the valve.  For a diagnostic TEE to be reimbursed, a written report (with documentation of medical necessity and findings) is required with images that can be retrieved.

**Question: Can the physiologic codes (93922, 93923) be reported more than once for upper and lower extremity studies?**

Yes. When both the upper and lower extremities are evaluated in the same setting, the applicable arterial code may be reported twice. Append modifier 59 to the second procedure. This identifies that the second procedure is separate and distinct from the first procedure.

**Question: How is saline reported for a bubble study?**

There isn't a specific echocardiography administration CPT code for saline echo studies. Saline is reported by the facility with the applicable drug code (e.g., A4216, J7050). The usual echocardiography service code CPT (e.g. 93306, 93350, 93351, or 93312) is reported. According to CPT Assistant (June 2005), Code 96374 (injection) may also be reported. However, some payers may not reimburse for it.  Medicare will likely not allow reporting of CPT 96374 with echocardiography, since there is an NCCI edit.  However, commercial payers may allow reporting of injection for a bubble study.

**Source Documents:**

* 2013 AMA CPT® Professional Edition , AMA CPT Knowledge Base, AMA CPT Assistant
* 2013 NCCI Manual
* CMS Claims Processing Manual

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